STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
IN-PATIENT HOSPITAL CARE

PART V.
INPATIENT HOSPITAL PAYMENT SYSTEM.

Article 1.
Application of Payment Methodologies.

12 VAC 30-70-200. Application of payment methodologies.

The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a DRG-based methodology. This methodology uses both per case and per diem payment methods. Article 2 (12 VAC 30-70-220 et seq.) describes the DRG-based methodology, including both the per case and the per diem methods. Article 3 (12 VAC 30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130). Until claims can be processed and paid by the DRG payment methodology, interim payments to hospitals will continue to be made by the per diem payment methodology described at Article 3 (12 VAC 30-70-400) and cost settled at the DRG amount when the hospitals' cost reports are settled at year end. The limit of coverage for adults of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply in the processing of claims (interim payments). Transplant services shall not be subject to the provisions of this part. They shall continue to be subject to 12 VAC 30-50-100-through 12 VAC 30-50-310 and 12 VAC 30-50-540.

12 VAC 30-70-201. Prior notice of onset of claims processing system. DMAS shall provide prior notice to the onset of the DRG claims process system in the *Virginia Register of Regulations* as well as direct notices to all affected hospitals. As DMAS develops regulations, it shall consult with affected provider groups.

Article 2.
DRG-Based Payment Methodology.

12 VAC 30-70-210. Reserved.

12 VAC 30-70-220. General.

A. Effective July 1, 1998, the DRG payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--
INPATIENT HOSPITAL CARE

Article 2.
Transition Period.

12 VAC 30-70-210. Transition period reimbursement rules.

A. Effective July 1, 1996, the state agency's reimbursement methodology for inpatient hospital services shall begin a transition from a prospective per diem to a prospective diagnosis related groupings (DRG) methodology. During the transition period, reimbursement of operating costs shall be a blend of a prospective DRG methodology (described in Article 3 of this part) and a revised prospective per diem methodology (described in Article 4 of this part). The transition period shall be SFY1997 and 1998, after which a DRG methodology alone shall be used.

B. Tentative payment during the transition period. During the transition period claims will be tentatively paid on the basis of the revised per diem methodology only. Payment of claims based on DRG rates shall begin July 1, 1998.

C. Final operating reimbursement during the transition period. During the transition period settlement of each hospital fiscal year will be carried out as provided in 12 VAC 30-70-460. Each hospital's final reimbursement for services that accrue to each state fiscal year of the transition shall be based on a blend of the prospective DRG methodology and the revised per diem methodology. For services to patients admitted and discharged in SFY1997 the blend shall be 1/3 DRG and 2/3 revised per diem. For services to patients admitted after June 30, 1996, and discharged during SFY1998 the blend shall be 2/3 DRG and 1/3 revised per diem. Settlements shall be completed according to hospital fiscal years, but after June 30, 1996, changes in rates and in the percentage of reimbursement that is based on DRGs vs. per diem rates, shall be according to state fiscal year. Services in freestanding psychiatric facilities licensed as hospitals shall not be subject to the transition period phase-in of new rates, or to settlement at year end; the new system rates for these providers shall be fully effective on July 1, 1996. In hospital fiscal years that straddle the implementation date (years starting before and ending after July 1, 1996) operating costs must be settled partly under the old and partly under the new methodology:

1. Days related to discharges occurring before July 1, 1996, shall be settled under the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130).

2. Stays with admission date before July 1, 1996, and discharge date after June 30, 1996, shall be settled in two parts, with days before July 1, 1996, settled on the basis of the previous reimbursement methodology (see 12 VAC 30-70-10 through 12 VAC 30-70-130), and days after June 30, 1996, settled at 100% of the hospital's revised per diem rate as described in Article 4 (12 VAC 30-70-400 et seq.) of this part. The DRG reimbursement methodology shall not be used in the settlement of any days related to a stay with an admission date before July 1, 1996.

3. Stays with admission dates on and after July 1, 1996, shall be settled under the transition methodology. All cases admitted from July 1, 1996, onward shall be settled based on the rates and transition rules in effect in the state fiscal year in which the discharge falls. The only exception shall be claims for rehabilitation cases with length of stay sufficient that one or more interim claims are submitted. Such claims for rehabilitation cases shall be settled based on rates and rules in effect at the time of the end date ("through" date) of the claim, whether or not it is the final or discharge claim.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

DRG payment system is rebased and recalibrated. For State Fiscal Year 1999, the base year shall be State Fiscal Year 1997.

2. "Groupable cases" are DRG cases having coding data of sufficient quality to support DRG assignment.

3. "DRG cases" are medical/surgical cases subject to payment on the basis of DRGs and include groupable, ungroupable, and transfer cases. DRG cases do not include per diem cases.

4. "Ungroupable cases" are cases assigned to DRG 469 (principal diagnosis invalid as discharge diagnosis) and DRG 470 (ungroupable) as determined by the AP-DRG Grouper.

5. "Per diem cases" are cases subject to per diem payment and include (i) covered psychiatric cases in general acute care hospitals and distinct part units (DPUs) of general acute care hospitals (hereinafter "acute care psychiatric cases"), (ii) covered psychiatric cases in freestanding psychiatric facilities licensed as hospitals (hereinafter "freestanding psychiatric cases"), and (iii) rehabilitation cases in general acute care hospitals and rehabilitation hospitals (hereinafter "rehabilitation cases").

   Psychiatric cases are cases with a principal diagnosis that is a mental disorder as specified in the ICD-9-CM. Not all mental disorders are covered. For coverage information, see the Amount, Duration, and Scope of Services, Supplement 1 to Attachment 3.1 A&B (12 VAC 30-50-95 through 12 VAC 30-50-310). The limit of coverage of 21 days in a 60-day period for the same or similar diagnosis shall continue to apply to adult psychiatric cases.

6. "Transfer cases" are DRG cases involving patients (i) who are transferred from one general acute care hospital to another for related care or (ii) who are discharged from one general acute care hospital and admitted to another for the same or a similar diagnosis within five days of that discharge. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

7. "Readmissions" occur when patients are readmitted to the same hospital for the same or a similar diagnosis within five days of discharge. Such cases shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD-9-CM diagnosis codes possessing the same first three digits.

8. "Outlier cases" are those DRG cases, including transfer cases, in which the hospital's adjusted operating cost for the case exceeds the hospital's operating outlier threshold for the case.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

9. The "operating cost-to-charge ratio" equals the hospital's total operating costs, less any applicable operating costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. In the base year, this ratio shall be calculated for each hospital by (i) calculating the average of the ratio over the most recent five years for which data are available and (ii) trending the hospital specific average forward from the mid-point of the five year period with a statewide trend factor. For State Fiscal Year 1999, data for State Fiscal Years 1991 through 1995 shall be used. The statewide trend factor shall be the average of the four annual statewide aggregate factors of change that occurred in the five year period. This trend factor shall be compounded from the mid point of the five year period to the base year.

10. The "capital cost-to-charge ratio" equals the hospital's total capital costs, less any applicable capital costs for a psychiatric DPU, divided by the hospital's total charges, less any applicable charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in subdivision 7 of this subsection.

11. The "psychiatric operating cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital is the hospital's operating costs for a psychiatric DPU divided by the hospital's charges for a psychiatric DPU. In the base year, this ratio shall be calculated as described in subdivision 7 of this subsection, using data from psychiatric DPUs.

12. The "psychiatric capital cost-to-charge ratio" for the psychiatric DPU of a general acute care hospital is the hospital's capital costs for the psychiatric DPU divided by the hospital's charges for the psychiatric DPU. In the base year, this ratio shall be calculated as described in subdivision 7 of this subsection, using data from psychiatric DPUs.

13. The "statewide average labor portion of operating costs" is a fixed percentage applicable to all hospitals. The percentage shall be periodically revised using the most recent reliable data from the VHSCRC/VHI.

14. The "Medicare wage index" and the "Medicare geographic adjustment factor" are published annually in the *Federal Register* by the Health Care Financing Administration. The indices and factors used in this article shall be those in effect in the base year.

15. The "outlier operating fixed loss threshold" is a fixed dollar amount applicable to all hospitals that shall be calculated in the base year so as to result in an expenditure for outliers operating payments equal to 5.1 percent of total operating payments for DRG cases. The threshold shall be updated in subsequent years using the same inflation values applied to hospital rates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

16. The "outlier adjustment factor" is a fixed factor published annually in the *Federal Register* by the Health Care Financing Administration. The factor used in this article shall be the one in effect in the base year.

17. The "DRG relative weight" is the average standardized costs for cases assigned to that DRG divided by the average standardized costs for cases assigned to all DRGs.

18. The "hospital case-mix index" is the weighted average DRG relative weight for all cases occurring at that hospital.

19. The "base year standardized costs per case" reflects the statewide average hospital costs per discharge for DRG cases in the base year. The standardization process removes the effects of case-mix and regional variations in wages and geography from the claims data and places all hospitals on a comparable basis.

20. The "base year standardized costs per day" reflect the statewide average hospital costs per day for per diem cases in the base year. The standardization process removes the effects of regional variations in wages and geography from the claims data and places all hospitals on a comparable basis. Base year standardized costs per day were calculated separately, but using the same calculation methodology, for the different types of per diem cases identified in subdivision 4 of this subsection.

21. A "disproportionate share hospital" is a hospital that meets the following criteria:

a. A Medicaid utilization rate in excess of 15 percent, or a low-income patient utilization rate exceeding 25 percent (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

b. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a state Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

c. Subdivision 21b of this subsection does not apply to a hospital:

(1) At which the inpatients are predominantly individuals under 18 years of age; or

(2) Which does not offer nonemergency obstetric services as of December 21, 1987.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
IN-PATIENT HOSPITAL CARE

22. The "Medicaid utilization percentage" is equal to the hospital's total Medicaid inpatient days divided by the hospital's total inpatient days for a given hospital fiscal year. The Medicaid utilization percentage includes days associated with inpatient hospital services provided to Medicaid patients but reimbursed by capitated managed care providers.

23. "Type One" hospitals are those hospitals that were state-owned teaching hospitals on January 1, 1996. "Type Two" hospitals are all other hospitals.

24. "Cost" means allowable cost as defined in Supplement 3 and by Medicare principles of reimbursement.

D. The All Patient Diagnosis Related Groups (AP-DRG) Grouper shall be used in the DRG payment system. Effective July 1, 1998, and until notification of a change is given, Version 14.0 of this grouper shall be used. DMAS shall notify hospitals by means of a Medicaid Memo when updating the system to later grouper versions.

E. The primary data sources used in the development of the DRG payment methodology were the Department's hospital computerized claims history file and the cost report file. The claims history file captures available claims data from all enrolled, cost-reporting general acute care hospitals, including Type One hospitals. The cost report file captures audited cost and charge data from all enrolled general acute care hospitals, including Type One hospitals. The following table identifies key data elements that were used to develop the DRG payment methodology and that will be used when the system is recalibrated and rebased.

Data Elements for DRG Payment Methodology

Data Elements	*Source*
Total charges for each groupable case	Claims history file
Number of groupable cases in each DRG	Claims history file
Total number of groupable cases	Claims history file
Total charges for each DRG case	Claims history file
Total number of DRG cases	Claims history file
Total charges for each acute care psychiatric case	Claims history file
Total number of acute care psychiatric days for each acute care hospital	Claims history file
Total charges for each freestanding psychiatric case	Claims history file
Total number of psychiatric days for each freestanding	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

Data Elements	*Source*
psychiatric hospital	Claims history file
Total charges for each rehabilitation case	Claims history file
Total number of rehabilitation days for each acute care and freestanding rehabilitation hospital	Claims history file
Operating cost-to-charge ratio for each hospital	Cost report file
Operating cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	VA Health Service Cost Review Council/VHI
Psychiatric operating cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Medicare cost report
Capital cost-to-charge ratio for each hospital	Cost report file
Capital cost-to-charge ratio for each freestanding psychiatric facility licensed as a hospital	VA Health Service Cost Review Council/VHI
Psychiatric capital cost-to-charge ratio for the psychiatric DPU of each general acute care hospital	Medicare cost report
Statewide average labor portion of operating costs	VA Health Service Cost Review Council/VHI
Medicare wage index for each hospital	*Federal Register*
Medicare geographic adjustment factor for each hospital	*Federal Register*
Outlier operating fixed loss threshold	Claims History File
Outlier adjustment factor	*Federal Register*

12 VAC 30-70-230. Operating payment for DRG cases.

A. The operating payment for DRG cases that are not transfer cases shall be equal to the hospital specific operating rate per case, as determined in 12 VAC 30-70-310, times the DRG relative weight, as determined in 12 VAC 30-70-380.

B. Exceptions.

1. Special provisions for calculating the operating payment for transfer cases are provided in 12 VAC 30-70-250.

2. Readmissions shall be considered a continuation of the same stay and shall not be treated as a new case.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

---

12 VAC 30-70-240. Operating payment for per diem cases.

A. The operating payment for acute care psychiatric cases and rehabilitation cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12 VAC 30-70-320, times the covered days for the case.

B. The payment for freestanding psychiatric cases shall be equal to the hospital specific rate per day for freestanding psychiatric cases, as determined in subsection B of 12 VAC 30-70-320, times the covered days for the case.

12 VAC 30-70-250. Operating payment for transfer cases.

A. The operating payment for transfer cases shall be determined as follows:

1. A transferring hospital shall receive the lesser of (i) a per diem payment equal to the hospital's DRG operating payment for the case, as determined in 12 VAC 30-70-230, divided by the arithmetic mean length of stay for the DRG into which the case falls times the length of stay for the case at the transferring hospital or (ii) the hospital's full DRG operating payment for the case, as determined in 12 VAC 30-70-230. The transferring hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-260, if applicable criteria are satisfied.

2. The final discharging hospital shall receive the hospital's full DRG operating payment, as determined in 12 VAC 30-70-230. The final discharging hospital shall be eligible for an outlier operating payment, as specified in 12 VAC 30-70-260, if applicable criteria are satisfied.

B. Exceptions.

1. Cases falling into DRGs 456, 639, or 640 shall not be treated as transfer cases. Both the transferring hospital and the final discharging hospital shall receive the full DRG operating payment.

2. Cases transferred to or from a psychiatric or rehabilitation DPU of a general acute care hospital, a freestanding psychiatric facility licensed as a hospital, or a rehabilitation hospital shall not be treated as transfer cases.

12 VAC 30-70-260. Outlier operating payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

A. An outlier operating payment shall be made for outlier cases. This payment shall be added to the operating payments determined in 12 VAC 30-70-230 and 12 VAC 30-70-250. Eligibility for the outlier operating payment and the amount of the outlier operating payment shall be determined as follows:

1. The hospital's adjusted operating cost for the case shall be estimated. This shall be equal to the hospital's total charges for the case times the hospital's operating cost-to-charge ratio, as defined in subsection C of 12 VAC 30-70-220, times the adjustment factor specified in 12 VAC 30-70-330.

2. The adjusted outlier operating fixed loss threshold shall be calculated as follows:

   a. The outlier operating fixed loss threshold shall be multiplied by the statewide average labor portion of operating costs, yielding the labor portion of the outlier operating fixed loss threshold. Hence, the non-labor portion of the outlier operating fixed loss threshold shall constitute one minus the statewide average labor portion of operating costs times the outlier operating fixed loss threshold.

   b. The labor portion of the outlier operating fixed loss threshold shall be multiplied by the hospital's Medicare wage index, yielding the wage adjusted labor portion of the outlier operating fixed loss threshold.

   c. The wage adjusted labor portion of the outlier operating fixed loss threshold shall be added to the non-labor portion of the outlier operating fixed loss threshold, yielding the wage adjusted outlier operating fixed loss threshold.

3. The hospital's outlier operating threshold for the case shall be calculated. This shall be equal to the wage adjusted outlier operating fixed loss threshold times the adjustment factor specified in 12 VAC 30-70-330 plus the hospital's operating payment for the case, as determined in 12 VAC 30-70-230 or 12 VAC 30-70-250.

4. The hospital's outlier operating payment for the case shall be calculated. This shall be equal to the hospital's adjusted operating cost for the case minus the hospital's outlier operating threshold for the case. If the difference is less than or equal to zero, then no outlier operating payment shall be made. If the difference is greater than zero, then the outlier operating payment shall be equal to the difference times the outlier adjustment factor.

B. An illustration of the above methodology is found in 12 VAC 30-70-500.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - IN-PATIENT HOSPITAL CARE

C. The outlier operating fixed loss threshold shall be recalculated using base year data when the DRG payment system is recalibrated and rebased. The threshold shall be calculated so as to result in an expenditure for outlier operating payments equal to 5.1 percent of total operating payments, including outlier operating payments, for DRG cases. The methodology described in subsection A of this section shall be applied to all base year DRG cases on an aggregate basis, and the amount of the outlier operating fixed loss threshold shall be calculated so as to exhaust the available pool for outlier operating payments.

12 VAC 30-70-270. Payment for capital costs.

A. Until regulations for prospective payment of capital costs are promulgated, capital costs shall continue to be paid on an allowable cost basis and settled at the hospital's fiscal year end, following the methodology described in Supplement III (12 VAC 30-70-10 through 12 VAC 30-70-130).

B. The exception to the policy immediately is that the hospital-specific rate per day for services in freestanding psychiatric facilities licensed as hospitals, as determined in 12 VAC 30-70-320, shall be an all-inclusive payment for operating and capital costs.

C. DMAS plans to implement prospective payment for capital costs for all DRG cases, acute care psychiatric cases, and rehabilitation cases. The implementation date will be determined later. Under prospective payment for capital costs, the Department will calculate a hospital specific capital rate and a statewide capital rate, and the two rates will be blended during a transition period. In successive years of the transition period, the statewide capital rate will comprise an increasing portion of the blended rate, until payment for capital costs is entirely based on the statewide capital rate. The two rates will be calculated as follows:

1. The hospital specific capital rate will approximate the hospital's average capital cost per case for DRG cases or the hospital's average capital cost per day for per diem cases. Initially, this rate will be based on settled cost reports for hospital fiscal years ending in a State Fiscal Year to be established in future regulations. Capital obligated after July 1, 1997 shall not be included in the calculation of the hospital specific capital rate.

2. The statewide capital rate will approximate the statewide average capital cost per case for DRG cases or the statewide average capital cost per day for per diem cases. Initially, this rate will be based on settled cost reports for hospital fiscal years ending in State Fiscal Year 1997.